DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	
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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155675	B. WIN			03/17/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AKEVIEW DR		
MORNING BREEZE RETIREMENT COMMUNITY AND HEALT			HC	1	NSBURG, IN47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
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10000	State Licensure s		100				
	State Licensure s	survey.					
	C 1.4 M						
	•	farch 14, 15, 16, and 17,					
	2011						
	Facility number:						
	Provider number	155675					
	AIM number: 20	00299100					
	Survey team:						
	Diana Sidell RN.	TC					
	Penny Marlatt R	•					
	-	N (March 14, 15, and 16,					
	2011)	14 (14141611 14, 13, 4114 10,					
	2011)						
	Can area la a 4 tamas						
	Census bed type:						
	SNF/NF: 19						
	SNF: 26						
	Residential: 23						
	Total: 68						
	Census payor typ	be:					
	Medicare: 15						
	Medicaid: 15						
	Other: 38						
	Total: 68						
	Sample: 12						
	Residential samp	ale: 7					
	residential samp						
	Those deficiencie	es also reflect state					
	indings in accor	dance with 410 IAC 16.2.					
					!		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6SB711 Facility ID: 011039

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION		DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING			COMPLETED
		155675	B. WIN	IG		- 0	3/17/2011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP COL	DE .	
				1	AKEVIEW DR		
MORNIN	G BREEZE RETIRE	EMENT COMMUNITY AND HE	ALTHC	GREEN	SBURG, IN47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Quality review co Cathy Emswiller	ompleted 3-22-11 RN					
	This visit was for State Licensure s	r a Recertification and survey.					
	Survey dates: March 14, 15, 16, and 17, 2011						
	Facility number:	011039					
	Provider number						
	AIM number: 20						
	7 min namoer. 20	30233100					
	Survey team:						
	Diana Sidell RN.	TC					
	Penny Marlatt R						
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	2011)						
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	Census payor typ	ne.					
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FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	6SB711	Facility I	D: 011039 If contin	uation sheet	Page 2 of 13

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPLETED	
		155675	B. WIN		-	03/17/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF P	PROVIDER OR SUPPLIER				AKEVIEW DR		
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	findings in accor	dance with 410 IAC 16.2.					
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	Quality review co	ompleted 3-22-11					
	Cathy Emswiller	-					
	This visit was for	r a Recertification and					
	State Licensure s	survev.					
	Survey dates: M	farch 14, 15, 16, and 17,					
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	2011						
	Facility number:	011030					
	Provider number						
	AIM number: 20	JU2991UU					
	G .						
	Survey team:	TO.					
	Diana Sidell RN,						
	Penny Marlatt R						
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	2011)						
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6SB711

Facility ID:

011039

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	COMPLETED	
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		EMENT COMMUNITY AND HEAL	THC	GREEN	ISBURG, IN47240		_	
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	Total: 68							
	Census payor typ	pe:						
	Medicare: 15							
	Medicaid: 15							
	Other: 38							
	Total: 68							
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	Residential samp	ole. 7						
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	l · -	completed 3-22-11						
	Cathy Emswiller	RN						
	TELL LA C	n - D i C 4 i	1					
		r a Recertification and						
	State Licensure	survey.						
	1 *	Iarch 14, 15, 16, and 17,						
	2011							
	Facility number:	011039						
	Provider number	:: 155675						
	AIM number: 2	00299100						
	Survey team:							
	Diana Sidell RN	. TC						
	Diana Diacii Kiv	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<u> </u>	MULTIPLE CO ILDING	NSTRUCTION	(X3) DATE COMP		
		155675	B. WI			03/17/2	2011
	PROVIDER OR SUPPLIER	EMENT COMMUNITY AND HEA	LTHC	950 N L	DDRESS, CITY, STATE, ZIP CODE AKEVIEW DR ISBURG, IN47240	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
PREFIX	Penny Marlatt R Sharon Lasher R 2011) Census bed type SNF/NF: 19 SNF: 26 Residential: 23 Total: 68 Census payor typ Medicare: 15 Medicaid: 15 Other: 38 Total: 68 Sample: 12 Residential samp These deficiencie findings in accord	De: 7 es also reflect state dance with 410 IAC 16.2. completed 3-22-11			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155675	B. WING			03/17/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			950 N I	_AKEVIEW DR		
		EMENT COMMUNITY AND HEALT	HC		NSBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	E0.4	TAG	This Plan of Correction constit		DATE
F0441		ation, interview, and	F04	41	our written allegation of	ues	03/28/2011
SS=E	· ·	e facility failed to	compliance for the defici			3	
	_	unitary and comfortable			cited. However, submission of		
	environment to h				Plan of Correction is not an		
	development and	transmission of disease			admission that a deficiency ex	ists	
	and infection in t	hat a blood glucose			or that the one was cited correctly. The Plan of Correction	an l	
	meter was not dis	sinfected for 2 of 2			is submitted to meet	J11	
	observations and	1 of 2 glucose meters.			requirements established by s	tate	
	This deficient pra	actice had the potential to			and federal law. It is the policy	of	
	affect 13 resident	ts. (Resident #45)			this facility to establish and		
	Findings include:				maintain an Infection Control	_	
					Program designed to provide a safe, sanitary and comfortable		
					environment and to help preve		
	On 3/15/11 at 4:4	40 p.m., LPN #1 was			the development and		
		blood glucose meter on			transmission of disease and		
	_	ter the blood glucose			infection. How corrective action		
		LPN #1 used an alcohol			has been or will be accomplish for those residents found to ha		
					been affected by the deficient	IVC	
		meter. During an			practice?The facility has review	wed	
		time, LPN #1 indicated			the alleged deficient practice of		
		nol wipes to clean the			Nurse #1 wiping the glucomete	er	
	glucometer."				machine with an alcohol wipe.		
					This facility follows CDC guidelines and manufacture's		
		0 p.m., LPN #1 was			quidelines to ensure proper		
	observed using a	blood glucose meter to			cleaning and disinfection of		
	recheck resident	#45's blood sugar. After			glucometers.The nurse caring	for	
	the blood glucose	e meter was used, LPN			Resident #45 has been		
	#1 used an alcoh	ol wipe to clean the			reeducated on the facility polic for cleaning glucometers. How	,	
	meter.				facility has identified or will	uic	
					identify other residents having	the	
	Manufacturer's g	uidelines for cleaning			potential to be affected by the		
	and disinfecting the glucose meter was				same deficient practice?All		
		Administrator on 3/17/11			residents receiving blood glucose		
1 -		guidelines indicated			monitoring with a glucometer has a potential to be affected,	ia5	
	ut 5.50 u.m. The	Saracinies maieatea			a potential to be allected,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6SB711

Facility ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION (X3)		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155675	B. WIN			03/17/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	£		950 N L	AKEVIEW DR		
		EMENT COMMUNITY AND HEALT	ГНС		ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	 	TAG	however none of the 13 were		DATE
		ne meter, dilute 1 mL			affected by the alleged deficie	nt	
	(milliliter) of household bleach (5%-6%				practice.What measures have		
	1	orite solution) in 9 mL of	been or will be put into place or				
		1:10 dilution. The final			systemic changes made to		
	concentration is	0.5-0.6% sodium			ensure that the deficient practi		
	hypochlorite. De	o not clean inside the			will not recur facility wide?The Director of Nursing reeducated		
	battery compartr	nent, code chip port, or			licensed nursing staff on the	1	
	test strip port"				facility guideline for cleaning o	r	
					glucometer machines. (See		
	A policy for "Gl	ucose Meters and			attached inservice materials		
	Infection Contro	l", with a review date of			used- Exhibit A).How your faci will monitor it corrective action		
		ided by the Administrator			ensure that the deficient practi		
		30 a.m. The policy			is being corrected and will not		
	included, but wa				recur?Effective 3/28/11 a qua		
	•	al surfaces and equipment			assurance program was		
	such as glucose				implemented under the supervision of the Director of		
	1	regularly, and any time			Nursing to monitor compliance	2	
		rith blood or body fluids			with cleaning of glucometers.		
		ected. Glucose meters			Director of Nursing or designe		
	_				will preform the following		
	_	ed to individual patients.			systemic changes: observe a		
	1	s are shared between			sample of blood glucose testin 4 weeks to ensure compliance		
		ices should be <u>cleaned</u>			with the facility guideline of		
		petween each patient			cleaning and disinfecting of the	е	
	use"				glucometer machine. Any		
					deficiencies will be corrected of		
	On 3/17/11 at 4:	_			the spot, and the findings of the QA checks will be documented		
	_	rovided a list of 13			and submitted to the Quality	1	
	resident's names	who receive routine			Assurance committe quarterly	for	
	blood glucose checks.				further review or corrective act		
					(See attached audit tool- Exhil	oit	
	During an interview on 3/17/11 at 5:05				B.)		
	p.m., the Admini	istrator and Director of					
	Nurses indicated	the nurses were to clean					

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Event ID: 6SB711

Facility ID:

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PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE COMP	
111,2 12,111	or condition	155675	A. BU B. WI	ILDING NG		03/17/2011	
	PROVIDER OR SUPPLIER	II S EMENT COMMUNITY AND HEAI		STREET A	ADDRESS, CITY, STATE, ZIP CODE AKEVIEW DR ISBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
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PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	A. BU	JILDING		COMP: 03/17/2	LETED
	PROVIDER OR SUPPLIER		B. WI	STREET A	ADDRESS, CITY, STATE, ZIP CODE AKEVIEW DR ISBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	This state resider accordance with	ntial finding is cited in 410 IAC 16.2-5.					
	Quality review of Cathy Emswiller	ompleted 3-22-11 RN					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 03/17/2011	
	PROVIDER OR SUPPLIER	EMENT COMMUNITY AND HEALT		STREET A	ADDRESS, CITY, STATE, ZIP CODE AKEVIEW DR ISBURG, IN47240	•		
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	Quality review concepts Cathy Emswiller	ompleted 3-22-11 RN						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675				ILDING	NSTRUCTION	(X3) DATE COMP 03/17/2	LETED
	PROVIDER OR SUPPLIER	IL : EMENT COMMUNITY AND HEAL	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE AKEVIEW DR ISBURG, IN47240		
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R0000	accordance with		R0	000			
	Quality review c Cathy Emswiller	ompleted 3-22-11 RN					

NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIXT BE PERCEIDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Based on record review and interview the facility failed to ensure staff had first aid training for 5 of 7 employee files reviewed. This deficient practice had the potential to affect 23 residential residents. (QMA #1, LPN #9, LPN #14, CNA #24, and CNA #41) The employee record review was completed on 3/17/11 at 11:40 a.m. The employee record review indicated none of the staff were certified in first aid. Five staff; two LPN's, two CNAs and one QMA were identified by the administrator as being assigned routinely to the residential hall. QMA #1 had a start date of 5-6-99, LPN #14 had a start date of 5-13-08, and CNA #41 had a start date of 7-15-10. SIRRETA ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 17240 STRECT ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 17240 STRECT ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 17240 STRECT ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 17240 SON LAKEVIEW DR GREENSBURG, IN 17240 This Plan of Correction constitues our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly. The Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly. The Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly in the submission of the Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly in the submission of the Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly in the submission of the Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly in the de	i '		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Based on record review and interview the facility failed to ensure staff had first aid training for 5 of 7 employee files reviewed. This deficient practice had the potential to affect 23 residential residents. (QMA #1, LPN #9, LPN #14, CNA #24, and CNA #41) Findings included: The employee record review was completed on 3/17/11 at 11:40 a.m. The employee record review indicated none of the staff were certified in first aid. Five staff; two LPN's, two CNAs and one QMA were identified by the administrator as being assigned routinely to the residential hall. QMA #1 had a start date of 5-1-06, LPN #9 had a start date of 5-1-3-08, and CNA #41 had a start date of 7-15-10. STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSDURG, INTO ATTO AND ATTO AND	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			COMPLETED	
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MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC SUMMARY STATEMENT OF DEFICIENCIES TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review and interview the facility failed to ensure staff had first aid training for 5 of 7 employee files reviewed. This deficient practice had the potential to affect 23 residential residents. (QMA #1, LPN #9, LPN #14, CNA #24, and CNA #41) The employee record review was completed on 3/17/11 at 11:40 a.m. The employee record review indicated none of the staff were certified in first aid. Five staff; two LPN's, two CNAs and one QMA were identified by the administrator as being assigned routinely to the residential hall. QMA #1 had a start date of 5-1-06, LPN 4had a start date of 5-13-08, and CNA #41 had a start date of 7-15-10.	NAME OF P	PROVIDER OR SUPPLIER	}					
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R0117 Based on record review and interview the facility failed to ensure staff had first aid training for 5 of 7 employee files reviewed. This deficient practice had the potential to affect 23 residential residents. (QMA #1, LPN #9, LPN #14, CNA #24, and CNA #41) Findings included: The employee record review was completed on 3/17/11 at 11:40 a.m. The employee record review indicated none of the staff were certified in first aid. Five staff; two LPN's, two CNAs and one QMA were identified by the administrator as being assigned routinely to the residential hall. QMA #1 had a start date of 5-13-08, and CNA #41 had a start date of 5-13-08, and CNA #41 had a start date of 7-15-10. R0117 This Plan of Correction constitues our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that the one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to establish and maintain that staff have required first aid those who have contact with residential residents. How corrective action has been or will be accomplished for those residents found to have been affected by the deficient practice? The facility has reviewed the alleged deficient practice of nursing staff. QMA#1, LPN#9, LPN#14, CNA#24, and CNA#41. This facility follows state guidelines that nursing staff members are required to be first aid certified. The staff careing for residental residents has been recducated that first aid certificates are needed. How the					GREEN	ISBURG, IN47240		_
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the residential halls on days and nights, the residential area have the		1						
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She indicated there were no employees none of the 23 were affected by		1					by	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6SB711

Facility ID:

011039

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155675		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/17/2011				
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC					STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE		
	p.m., the Admini is part of their or	iew on 3/17/11 at 4:57 strator indicated first aid ientation but after aff aren't certified.			systemic changes made to ensure that the deficient practi will not recur facility wide?The Director of Nursing reeducated residental nursing staff on the facility guideline for first aid training requirements. A mandatory training will occur of April 6, 2011 for first aid certificates.How your facility we monitor it corrective actions to ensure that the deficient practic is being corrected and will not recur?Effective 3/28/11 all new hires doing residential care will required to have a current first training certificate. Any staff memeber who is not first aid certified and is a residential cataker will be suspended after 4/6/11's mandatory inservice up their first aid certificate is gained.	on ill ce / I be aid			